

Seattle Journal for Social Justice

Volume 11 | Issue 2

Article 2

12-2013

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Recommended Citation

Michelle Fleishman, Bette (2013) "Invisible Minority: People Incarcerated with Mental Illness, Developmental Disabilities, and Traumatic Brain Injury in Washington's Jails and Prisons," *Seattle Journal for Social Justice*: Vol. 11 : Iss. 2 , Article 2.

Available at: <https://digitalcommons.law.seattleu.edu/sjsj/vol11/iss2/2>

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Invisible Minority: People Incarcerated with Mental Illness, Developmental Disabilities, and Traumatic Brain Injury in Washington's Jails and Prisons

Bette Michelle Fleishman*

The degree of civilization in a society can be judged by entering its
prisons.

- Fyodor Dostoyevsky¹

I. INTRODUCTION

The United States incarcerates more people than any other country in the

* The author would like to thank the inmates who were willing to share their experiences, information, and insights, as well as the Washington Department of Corrections and the local jails for access to their institutions and for sharing their experiences and perceptions.

The author would also like to acknowledge the law school students and Disability Rights Washington interns who provided research and shared their insights as we visited various jails and prisons together. Special thanks to Alexis De La Cruz, Kiran Griffith, Elizabeth Leonard, Heather Hightower, Alexa Mullarky, Anne Vankirk, Adam Chromy, Adrienne Wat, and Alex West.

Additionally, the author is deeply grateful to members of the legal community who took time to share views and experiences: Judge Coughenour, Judge McDermott, Judge Harper, Judge Spector, Judge Armstrong, Judge Finkel, Judge Kessler, Ada Shen-Jaffe, Gillian Dutton, Linda Worthington, Melissa Lee, Hank Balson, Wendy Chen, Nancy Talner, Bill Collins, Mark Larranaga, Margaret Fisher, Pat Valero, Louis Frantz, James Koenig, Kim Cronin, and Risa Collins. Thanks to Dr. Marc Stern, former Washington Department of Corrections medical director, for sharing his insights. Finally, a special thanks to Cindy Arends for her support and friendship.

The author is grateful to Seattle University School of Law for funding the fellowship and to Disability Rights Washington for being the host organization. The report reflects the views of the author, and does not necessarily reflect the opinions or positions of Seattle University School of Law or Disability Rights Washington.

¹ STANDS4 LLC, *Fyodor Dostoevsky Quotes*, QUOTES.NET, <http://www.quotes.net/quote/20039> (last visited Feb. 26, 2013).

world, and 2.3 million people are in the nation's prisons² or jails today: a five-fold increase over the past thirty years.³ This dramatically increased incarcerated population has generated national and statewide attention, including the first ever congressional hearings regarding the use of solitary confinement.⁴ The UN Special Rapporteur, Juan E. Méndez, citing scientific studies establishing the lasting mental damage of even a few days of social isolation, recently called for an absolute prohibition of solitary confinement for people with mental disabilities.⁵

Jails and prisons have become America's de facto mental hospitals,⁶ and since there is no independent oversight of correctional facilities in the United States,⁷ the incarcerated population is often invisible. Prisoners with mental illness, traumatic brain injuries, and other mental and intellectual disabilities, are an unrecognized and vulnerable minority. Although people with mental disabilities are a minority in the United States, they are rapidly

² Prisons are places of confinement for convicted criminals, and are also known as penitentiaries or correctional facilities. *Prison*, FREE DICTIONARY, <http://legal-dictionary.thefreedictionary.com/prison> (last visited Oct. 9, 2012). Washington State operates twelve prisons. Although identified as prisons in this article, the names of the facilities are either correctional centers and complexes or state penitentiaries. *Washington State Penitentiary*, WASH. DEP'T OF CORR., <http://www.doc.wa.gov/facilities/prison/wsp/default.asp> (last visited Oct. 9, 2012).

³ *Criminal Justice Fact Sheet*, NAACP, <http://www.naacp.org/pages/criminal-justice-fact-sheet> (last visited Oct. 12, 2012).

⁴ Lisa Guenther, Op-Ed, *The Living Death of Solitary Confinement*, N.Y. TIMES, Aug. 26, 2012, <http://opinionator.blogs.nytimes.com/2012/08/26/the-living-death-of-solitary-confinement/>.

⁵ Juan Méndez, *Solitary Confinement Should be Banned in Most Cases*, UN EXPERT SAYS, UN NEWS CENTRE, (Oct. 18, 2011), <http://www.un.org/apps/news/story.asp?NewsID=40097>.

⁶ See E. FULLER TORREY, M.D., ET AL., NAT'L SHERIFFS ASS'N, TREATMENT ADVOCACY CTR., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 9, 12 (2010), available at http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

⁷ Michael B. Mushlin & Michele Deitch, *Opening Up a Closed World: What Constitutes Effective Prison Oversight?*, 30 PACE L. REV. 1383, 1390–91 (2012).

becoming the majority within jails and prisons.

Two distinct public policies over the last forty years have led to a growing number of incarcerated people with mental illness: inadequate support by elected officials and punitive anti-crime measures.

First, elected officials have not provided adequate funding, support, or direction for the community mental health system, which was intended to replace the mental health hospitals that were shut down as part of the “deinstitutionalization” effort that begun in the 1960s.⁸ The result has been higher conviction rates of mentally ill people.⁹

Second, the punitive anti-crime efforts, such as the “War on Drugs,” have significantly expanded the number of people brought into the criminal justice system. One possibility is that people self-medicate, get swept up as drug offenders, and end up in the correctional system.

The impetus for this article¹⁰ was a report, *Concerning Persons with*

⁸ *The New Asylums* (PBS television broadcast May 14, 2005), available at <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/view/>.

⁹ FRED COHEN, *THE MENTALLY DISORDERED INMATE AND THE LAW* § 1.6 (2008).

¹⁰ This article is the product of a fellowship awarded in 2010 by Seattle University School of Law to the author to address the criminalization and incarceration of individuals with mental illness, developmental disabilities, and traumatic brain injuries in the state of Washington. The fellowship was housed at Disability Rights Washington (DRW), a non-profit and federally mandated organization designated by the governor as the Protection and Advocacy System for the state of Washington. Every state has a federally mandated Protection and Advocacy (P&A) organization. Congress created P&A organizations after the Willowbrook scandal unearthed the horrible conditions in that institution. This mandate includes access to any institution, including jails and prisons. In this capacity, DRW advocates on behalf of individuals with disabilities by providing information and referral services and legal representation, by monitoring facilities that serve these individuals, by conducting investigations into alleged incidents of abuse or neglect, and by participating in various public policy and educational initiatives.

Since the challenges for people with mental illness, I/DD, and TBI are often similar (particularly for people incarcerated) the investigation of conditions for people with I/DD and TBI led to investigation into the conditions for people with mental illness. One issue that continued to occur was people with a mental disability ending up in some type of solitary confinement, which led to an investigation into the use of solitary confinement as discipline for people with mental disabilities. As a result of the findings, a referral was made to the DRW legal team, who is currently investigating this issue.

Developmental Disabilities and Traumatic Brain Injury in Correctional Facilities and Jails.¹¹ A key finding of this report was the need to screen for inmates with intellectual developmental disabilities (I/DD)¹² and traumatic brain injury¹³ (TBI).¹⁴ The report represents a year of hard and conscientious work, however, no agency or individual was tasked with follow up or implementation of the report's recommendations.

As a response to the report, a fellowship project—which resulted in this article—was designed to gain an overview of the conditions for people incarcerated with mental disabilities, to make recommendations, and to hopefully be a catalyst for improving the conditions for this population in Washington State. The project started in September 2010, and it included monitoring Washington jails and prisons,¹⁵ interviewing jail and

¹¹ H.B. 2078 WORK GRP., CONCERNING PERSONS WITH DEVELOPMENTAL DISABILITIES AND TRAUMATIC BRAIN INJURY IN CORRECTIONAL FACILITIES AND JAILS: WORK GROUP REPORT (2009), *available at* http://www.ddc.wa.gov/Publications/091208_2078_Final_Report2.pdf [hereinafter WORK GROUP REPORT].

¹² I/DD (formerly known as Mental Retardation) is significantly sub-average general intellectual functioning that is accompanied by significant limitation in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety. The onset must occur before age 18 years old. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MANUAL OF MENTAL DISORDERS (4th ed. 2000). I/DD has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system. *Id.*

¹³ Traumatic Brain Injury is defined as “an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both” 34 C.F.R. § 300.8(c)(12) (2007). The term “applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory perceptual, and motor abilities; psycho-social behavior; physical functions; information processing; and speech.” *Id.* The term “does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma.” *Id.*

¹⁴ WORK GROUP REPORT, *supra* note 11.

¹⁵ The author visited and monitored seven jails (King, Kitsap, Pierce, Clark, Snohomish, Spokane, and Yakima Counties) and five Department of Corrections (DOC) facilities (Monroe Correctional Complex, Washington Corrections Complex for Women,

Department of Corrections (DOC) staff,¹⁶ interviewing inmates, reviewing records,¹⁷ and researching nationally accepted papers and reports.

Washington Corrections Center, Airway Heights Corrections Center, and Coyote Ridge Corrections Center). Several facilities were visited more than once.

The author made frequent visits to the Monroe prison because it is the site of the Special Offender Unit that houses the majority of inmates identified as having a mental disability. Early on in the project a group of inmates at Monroe were selected for ongoing interviews. The men included those who had been in the Special Offender Unit. However, with the tragic death of a Correctional Officer in January 2011, the prison was closed to outside visitors for approximately four months, limiting access to this group.

Originally, it was expected the author would spend a substantial amount of time monitoring King County Correctional Facility; however, since the jail is under a Memorandum of Agreement with the U.S. Department of Justice (DOJ), and because the DOJ was examining similar issues as the fellow, a decision was made to focus attention on other facilities.

¹⁶ Interviews were conducted from October 2010 to June 2011, and were performed with the understanding they would be confidential. The author interviewed dozens of staff at various facilities. Interviews were also conducted with jail and Washington DOC officials from the Monroe Correctional Complex, Washington Corrections Complex for Women, Washington Corrections Center, Airway Heights Corrections Center, Coyote Ridge Correction Center, Kitsap County Jail, King County Adult Detention, Pierce County Jail, Clark County Detention Center, Snohomish County Jail, Spokane County Jail, and Yakima County Corrections Department.

¹⁷ The author also requested records from both the DOC and the above-mentioned jails. The request included: (1) names of inmates with any mental disability in administrative segregation, disciplinary segregation, or an intensive management unit; (2) names of inmates with a mental disability who have been sanctioned within the last six months; (3) inmates charged with persistent prison misbehavior in the last six months; (4) requests received from inmates regarding medication or disability accommodations within thirty days of being transferred from one DOC facility to another; (5) suicides within the past six months; (6) reviews of follow up assessment for mental health; (6) assessment tool(s) for mental illness, I/DD, or TBI; (7) use of forced medication in the last thirty days; (8) information regarding change in formulary in the last six months; (9) policies, procedures, or correspondence regarding Legislative Work Group recommendations; and, (10) policies regarding use of segregation for people with mental disabilities, transfer of an inmate to another DOC facility, jail, or hospital, identification and prevention of suicide, initial mental health assessments, follow up assessments, forced medication, and use of medication at minimum security camps.

Additionally, the author maintained regular communication with the Resource & Advocacy staff at DRW, who often receive calls and letters from inmates in jails and DOC facilities. This correspondence was useful to observe common trends and to identify issues for further investigation.

This article, a final product of the fellowship project, identifies and documents many failures in the treatment of people with disabilities in Washington prisons and jails, and proposes changes to remedy many of these shortcomings.

II. JAILS AND PRISONS AS DE FACTO MENTAL HEALTH HOSPITALS: EXAMINING THE RATE OF I/DD, TBI, AND MENTAL ILLNESS IN THE INCARCERATED POPULATION.

Housing more individuals with mental illness than public and private psychological facilities combined, jails and prisons in the United States have become the de facto psychiatric facilities of the twenty-first century.¹⁸ A 2006 Bureau of Justice Statistics (BJS) Special Report, *Mental Health Problems of Prison and Jail Inmates*, shows that more than half of all individuals incarcerated in state prisons in the United States experience some form of mental health problem; the rate in local jails is even higher.¹⁹

In addition to highlighting the high prevalence of mental health problems,²⁰ the BJS report also discusses recidivism rates among prison and jail inmates.²¹ Nearly a quarter of both state and jail inmates who had mental health problems, compared to a fifth of inmates without mental health problems, had served three or more prior incarcerations.²² Only one in three state prisoners and one in six jail inmates who had a mental health

¹⁸ NAT'L PRISON RAPE ELIMINATION COMM'N, NATIONAL PRISON RAPE ELIMINATION COMMISSION REPORT 73 (2009), *available at* <http://ncjrs.gov/pdffiles1/226680.pdf> [hereinafter NAT'L PRISON RAPE ELIMINATION COMM'N REPORT].

¹⁹ DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, SPECIAL REPORT: MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), *available at* <http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf>.

²⁰ *Id.*

²¹ *Id.* Substance abuse was also a common problem. About 74 percent of state prisoners and 76 percent of local jail inmates who had a mental health problem met criteria for substance dependence or abuse. Nearly 63 percent of state prisoners who had a mental health problem had used drugs in the month before their arrest, compared to 49 percent of those without a mental health problem. *Id.*

²² *Id.*

problem had received treatment since admission.²³

A. The Washington Department of Corrections

It is important to understand that there are many differences between jails and prisons. Jails are for individuals awaiting trial and individuals with sentences less than one year.²⁴ Jails house both male and female detainees, are run by local jurisdictions, and have more turnover.²⁵ A jail also has the added problem of having a significant number of inmates coming through the system. It is not unusual for the larger jails to process over 60,000 inmates a year;²⁶ for example, Kitsap County jail has beds for 419 inmates and over 10,000 inmates are processed annually.²⁷

On the other hand, prisons separate inmates by gender, are run by the state or federal government, and have a lower turnover rate.²⁸ This makes prisons more predictable because inmates arrive at a scheduled time and know the length of their sentence, making it easier for DOC officials to coordinate logistics.

Additionally, prisons have heightened security facilities, which are often called “secure housing units,” “supermax security,” “solitary confinement,” or “intensive management units.”²⁹ Prisoners are sent into heightened security facilities for disciplinary or security reasons, and typically spend

²³ *Id.*

²⁴ *Jail*, FREE DICTIONARY, <http://www.thefreedictionary.com/jail> (last visited Oct. 9, 2012).

²⁵ *Id.*; CTR. FOR THERAPEUTIC JUSTICE, AMERICAN JAILS 1 (2000), available at <http://www.therapeuticjustice.com/programPDFs/JAILS%20are%20not%20prisons.pdf>.

²⁶ Interview with Kitsap Cnty. Jail Officials, in Port Orchard, Wash. (Oct. 2010).

²⁷ *Id.*

²⁸ Interviews with Jail and Wash. Dep’t of Corr. Officials, Dep’t of Corr. Reception Ctr. in Shelton, Wash. (Oct. 20, 2010 – June 20, 2011); Interviews with Jail and Wash. Dep’t of Corr. Officials, Wash. Corr. Ctr. for Women. in Gig Harbor, Wash. (Oct. 20, 2010 – June 20, 2011).

²⁹ These terms are often used interchangeably.

their hours alone, locked in small, sometimes windowless, cells.³⁰ These inmates are fed in their cells and are only periodically let out of their cells for showers and solitary exercise.³¹

1. Assessing New Inmates

The DOC and all jails perform some type of initial assessment of new inmates. The assessment in jails is more challenging than in prisons because jails have no advance notice of an inmate's arrival and because an inmate may be intoxicated or mentally unstable. In contrast, DOC has advance notice of all inmates who will arrive in a prison.³² Inmates are not transferred from jails to prisons until after they have been sentenced, at which point they have been, in most cases, stabilized. Typically, jails and prisons have several days' notice regarding transfers, and each can prepare for the transfer.³³

The average time an inmate will spend in the DOC reception center³⁴ is twenty-eight days.³⁵ In order to enhance communication between the jails and DOC, DOC has established a Behavioral Alert System,³⁶ which includes a full-time employee dedicated to communication with jails about

³⁰ Observations of author in Monroe Correctional Complex, Washington Corrections Complex for Women, Wash. Corr. Ctr., Airway Heights Corr. Ctr. and Coyote Ridge Corr. Ctr. [hereinafter Monitoring Facilities] (Oct. 2010–June 2011).

³¹ *Id.*

³² Interviews with Wash. Dep't of Corr. Officials, Wash. Corr. Complex for Women, in Gig Harbor, Wash. (Oct. 2010–Apr. 2011); Observations of fellow at Dep't of Corr. Reception Ctr., in Shelton, Wash. (Mar. 4, 2011, Mar. 11, 2011, Apr. 12, 2011, May 19, 2011).

³³ Interviews with Wash. Dep't of Corr. Officials, Wash. Corr. Complex for Women, in Gig Harbor, Wash. (Oct. 2010–Apr. 2011).

³⁴ The DOC reception center is where an inmate is initially classified to determine the level of security required, and which prison is most appropriate. During this time, the inmate is also assessed for medical and mental health concerns, and their educational level is determined. *Washington State Prisons*, WASH. DEP'T OF CORR., <http://www.doc.wa.gov/facilities/prison/default.asp> (last visited Nov. 17, 2012).

³⁵ *Id.*

³⁶ *Id.*

incoming inmates.³⁷ DOC added this position approximately four years ago, out of a concern that gang-affiliated inmates could be placed in the same cells as gang rivals, potentially resulting in violence.³⁸ The Behavioral Alert System focuses primarily on gang affiliation and past violent behavior, information that is critical for the safety of inmates and DOC employees alike,³⁹ and it appears that the communication system has succeeded in increasing safety.⁴⁰ However, the DOC should expand the program to include screening for mental health issues.

The initial assessment process, which is the first step in a twenty-eight day assessment period, is performed by the DOC shortly after an inmate arrives and is brief, often lasting only twenty minutes.⁴¹ If an inmate with a mental health issue is identified, the inmate will be referred for further evaluation.⁴² Additionally, once the inmate arrives at his or her home facility, which is determined by the results of the initial assessment, additional screening is completed.⁴³ The DOC does not track significant changes between the initial mental health assessment and the follow-up assessment.⁴⁴

In a number of inmate interviews, many who had been through the corrections classification and orientation process reported that they did not answer the questions regarding mental health honestly upon arrival to the DOC for several reasons: (1) the negative stigma associated with a mental health diagnosis; (2) a lack of understanding about how the information will

³⁷ Interview with Wash. Dep't of Corr. Officials, Wash. Corr. Ctr., in Shelton, Wash. (Mar. 4, 2011).

³⁸ *Id.*

³⁹ *Id.*; author's review of the Gang Affiliation Form used during the intake process.

⁴⁰ Interview with Wash. Dep't of Corr. Officials, Wash. Corr. Ctr., in Shelton, Wash. (Mar. 4, 2011).

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ Telephone Interview with Wash. Dep't of Corr. Official (Aug. 30, 2011).

be used;⁴⁵ (3) a lack of understanding regarding the importance of answering the questions honestly; and (4) an inability to pay attention to the questionnaire.⁴⁶ Because this process is likely to lead to an incomplete picture of the inmate's mental health, the DOC should look to additional sources of information.

2. Lack of Complete Information

Though an inmate may not provide complete information, there may be valuable information known by family members and community mental health professionals. Particularly for jails, where there is no advance warning of who will be entering the jail, having a mechanism by which family members and community mental health professionals could call the jail and pass along relevant health or mental health information would benefit everyone.

However, it is currently extremely difficult to call most jails and get connected to a nurse or mental health specialist. For example, in calling the King County Correctional Facility, several family members of inmates were sent from voicemail to voicemail for over twenty minutes and never reached the correct extension.⁴⁷ Therefore, there should be a direct line, answered by staff on duty, available for individuals to call with information regarding an inmate.

⁴⁵ Interviews with Inmates of Monroe Corr. Complex, in Monroe, Wash. (Oct. 2010–June 2011). For example, concern was expressed by a number of inmates that if they admit to a mental health issue, then they might be deprived privileges, particularly the opportunity to visit their children. *Id.*

⁴⁶ Inmates reported that they were often given the questionnaire after just coming off a bus and being given a shower, and while sitting—often in underwear—on a cold, cement bench, which made it difficult to pay attention. *Id.*

⁴⁷ To verify this, the author tried calling the jail and encountered similar results.

3. Evaluating New Inmates

The DOC uses Guideline PULHES Codes⁴⁸ to assign the level of health care services needed and to determine the best living and work placements for inmates.⁴⁹ Recently, a change was made to include a specific code (H) to identify inmates with developmental disabilities.⁵⁰

Although DOC has begun to recognize the importance of identifying inmates with developmental disabilities, as of May 2011, the DOC had identified only thirty-one individuals in the DOC system as having I/DD.⁵¹ However, in reviewing the records of 11,804 inmates, the fellow concluded that 117 inmates had a code identifying the individual as having a developmental disability.⁵² This disparity between the number of people in Washington who are believed to have some type of developmental disability (80,483), and the number determined to be eligible (37,483), indicates that DOC is not identifying all inmates with I/DD.⁵³

There are additional gaps in information regarding inmates with I/DD. For example, the DOC does not track the number of people with I/DD who have infractions as compared to people without I/DD.⁵⁴ DOC officials commented that they thought this would be a worthwhile statistic to have,

⁴⁸ PULHES codes are used to assign “level of health” service codes to offenders utilizing a uniform profiling system. Specific factors are evaluated: General Health Service Utilization (P); Medication Delivery Requirements (U); Limitations of Mobility (L); Developmental Disability (H); Sensory Disability (E); Mental Health Service Utilization (S); Dental Service Utilization (D); ADA Accommodation (X); and Transportation (T). WASH. DEP’T OF CORR., GUIDELINE PULHES CODES (on file with author).

⁴⁹ *Id.* Guidelines are confidential and were accessed by the author during her research.

⁵⁰ Interview with Wash. Dep’t of Corr. Official, Monroe Corr. Complex, in Monroe, Wash. (June 24, 2011, July 5, 2011). The author reviewed the form as well.

⁵¹ Interview with Wash. Dep’t of Corr. Official, Dep’t of Corr. Headquarters, in Lacey, Wash. (May 2011).

⁵² WASH. DEP’T OF CORR., INMATE RECORDS (2011).

⁵³ DAVID MALTMAN, HOUSE BILL 2078 WORK GRP., WHO ARE PEOPLE WITH DEVELOPMENTAL DISABILITIES? 5 (2009), available at http://www.ddc.wa.gov/Publications/090722_PPT_DD.pdf.

⁵⁴ Wash. Dep’t of Corr. Officials, *supra* note 35.

and that they are considering tracking the infractions of people with I/DD.⁵⁵

Currently, the DOC does not screen or code for people with TBI, and DOC officials attributed this to the lack of a valid screening tool.⁵⁶ In the past, the DOC administered IQ tests, but this practice was stopped several years ago.⁵⁷ Currently, the DOC administers a test to establish the reading levels of inmates.⁵⁸ Inmates who read below second-grade level go through additional testing to determine whether they have TBI. As of May 2011, 202 inmates were waiting for additional testing.⁵⁹

There is no formal identification on the mental health matrix for people with TBI.⁶⁰ Additionally, there are concerns about using reading level as a means to assess TBI. A comprehensive study of people incarcerated with TBI was recently completed in South Carolina.⁶¹ One of the researchers commented that the average reading level of incarcerated people with TBI was an eighth-grade level,⁶² which implies that this population might have the ability to read.⁶³ The more pressing issue is *whether individuals with TBI have the ability to make wise decisions, interpret what is being said, remember what is being said, and learn new information.*⁶⁴ Researches also

⁵⁵ Interview with Wash. Dep't of Corr. Official, Wash. Dep't of Corr., Headquarters, in Lacey, Wash. (Aug. 2011).

⁵⁶ Interview with Wash. Dep't of Corr. Official, Wash. Dep't of Corr., Headquarters, in Lacey, Wash. (May 2011).

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ The Mental Health Matrix is a confidential internal document used by the DOC to identify different mental illnesses. TBI is not a mental health diagnosis so it is not included. WASH. DEP'T OF CORR., MENTAL HEALTH MATRIX (reviewed by author).

⁶¹ Eric J. Shiroma et al., *Association of Medically Attended Traumatic Brain Injury and In-Prison Behavioral Infractions: A Statewide Longitudinal Study*, 16 J. CORRECTIONAL HEALTH CARE 273, 274 (2010), available at <http://jcx.sagepub.com/content/16/4/273.full.pdf+html>.

⁶² Telephone Interview with Elisabeth Pickelsimer, Research Assoc. Professor, Med. Coll. S.C. (Aug. 31, 2011).

⁶³ *Id.*

⁶⁴ *Id.*

observed that the younger a person was when the head injury occurred, the more likely it was for that person to have problems later on in life.⁶⁵ The DOC currently does not capture or account for these nuances in its screening process. It should update its health matrix to include a more comprehensive TBI screening process.

B. People with I/DD, TBI, and Mental Illness in Washington Prisons

The Washington DOC has established special units for people with mental disabilities. These units may also include inmates with identified I/DD.

The Special Offender Unit (SOU) is located at the Monroe Correctional Complex and has a maximum residential population of 364.⁶⁶ There are a total of 417 beds, but thirty-six of those beds are segregation beds for use when inmates are disciplined.⁶⁷ Of the remaining 364 treatment beds, an additional thirty-six are for inmates in maximum security and receiving treatment in the intensive treatment unit.⁶⁸ Typically, these maximum security inmates are locked down twenty-three hours a day.⁶⁹ There are an additional seventeen beds in a close observation area of the infirmary. These beds are for the temporary placement of inmates needing acute care and observation (such as suicide watch).⁷⁰

There is an additional residential mental health unit in the Washington State Penitentiary (WSP) that has 108 beds designated for people with mental illness and an additional 108 beds designated for either people with

⁶⁵ *Id.*

⁶⁶ Interviews with Wash. Dep't of Corr. Officials, Monroe Corr. Complex, in Monroe, Wash. (Oct. 14, 2010, Nov. 18, 2010, Dec. 22, 2010, Jan. 13, 2011, May 16, 2011, June 24, 2011, July 28, 2011). This information is also based on the author's review of records and personal observations.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

mental illness or inmates who are in some type of protective custody.⁷¹

Additionally, the Washington Corrections Center for Women has two units for women identified as having a mental illness, with a combined maximum capacity of forty-nine women.⁷² Specifically, the units consist of an acute care unit with sixteen beds and a residential mental health unit with thirty-three beds.⁷³ Correctional personnel reported that these beds are rarely full.⁷⁴ The women's prison also has forty segregation beds.⁷⁵ Often inmates who do not qualify for the mental health unit, but have some type of mental health issue, will be placed in segregation. A mental health professional does rounds three times a week for those inmates with mental disabilities.⁷⁶

As previously mentioned, seven facilities were selected for review of the conditions within the DOC.⁷⁷ The statistical analysis is attached to this report.⁷⁸ A few of the key findings include: (1) 35.8 percent of males and 56.6 percent of the females have a mental illness, which is significantly lower than the national projections for inmates in US state prisons;⁷⁹ (2) 5 percent percent (1,075 inmates) had schizophrenia or another psychotic disorder, but only 10.4 percent (112 inmates) of them were administered anti-psychotic medications; (3) 36.9 percent (397 inmates) of the inmates diagnosed with schizophrenia or another psychotic disorder were not

⁷¹ *Id.*

⁷² *Id.*

⁷³ Interviews with Wash. Dep't of Corr. Officials, Monroe Corr. Complex, in Monroe, Wash. (Oct. 14, 2010).

⁷⁴ *Id.* It unclear why the beds are rarely filled. It may be due to under-diagnosis of women who need the services.

⁷⁵ *Id.*

⁷⁶ Interview with Wash. Dept. of Corr. Official, Monroe Corr. Complex, in Monroe, Wash. (Nov. 18, 2010).

⁷⁷ See generally *infra* Appendix A (providing a complete breakdown of the facilities selected for review).

⁷⁸ See *infra* Appendix A.

⁷⁹ See *infra* Appendix A (providing national projections indicating that 55 percent of incarcerated men and 73 percent of incarcerated women have a mental illness).

receiving any medications; (4) 7.8 percent (1,752 inmates) were diagnosed with a mood disorder, but only 15.8 percent (276 inmates) were on mood-stabilizer medications; (5) 14.7 percent (2,001 inmates) were diagnosed with an anxiety disorder, but only 18.8 percent (376 inmates) were on anti-anxiety medication; (6) 56.6 percent (4,463 inmates) were diagnosed with some type of mental illness, but 60 percent (2,698 inmates) were not receiving any medications; and (7) 3.7 percent (167 inmates) had no mental health diagnosis, but nonetheless took psychotropic medications.⁸⁰

However, the DOC does not track this information, and was unable to provide some critical information.⁸¹ Additional information that DOC fails to track includes the following: (1) the number of people in any type of segregation with a mental illness, I/DD, or TBI; (2) the variance between inmates with mental health illness and inmates with no mental health illness in regard to rule violations; (3) the number of inmates who have been offered medication, but refuse to be medicated; (4) the prevalence of forced medication; and (5) the requests for kites⁸² that circulate internally at the prisons as inmates moved between facilities.⁸³

The Washington DOC is in the process of rewriting its Offender Mental Health Plan,⁸⁴ and prison officials and mental health teams are beginning to meet on a regular basis. Because the Washington prison population is relatively small compared to larger states, the DOC has an opportunity to become a leader in best practices for inmates with mental health issues.

⁸⁰ See *infra* Appendix A.

⁸¹ See *infra* Appendix A.

⁸² When inmates seek medical care, the request is called a “kite.” Kites make up inmates’ medical records, but when inmates are transferred from facility to facility, their medical treatment histories often do not follow them. See *Prison Life—Health Services*, WASH. DEP’T OF CORR., <http://www.doc.wa.gov/family/offenderlife/healthservices.asp> (last visited Mar. 6, 2013).

⁸³ See *infra* Appendix A.

⁸⁴ Interview with Jane Parnell, Superintendent, Wash. Corr. Ctr. for Women, in Gig Harbor, Wash. (Sept. 15, 2011).

Additionally, DOC initiated assistance from the Vera Institute of Justice, an organization who “partner[s] with . . . government . . . to help improve the systems people rely on for justice and safety.”⁸⁵ While the steps the DOC has taken are noteworthy, it must continue to act responsibly to ensure that inmates are provided appropriate services.

1. Intellectual Developmental Disability (I/DD)⁸⁶

The Revised Code of Washington (RCW) 71A.10.020 defines “developmental disability” as follows:

[A] disability attributable to intellectual disability, cerebral palsy, epilepsy, autism, or another neurological or other condition of an individual found by the secretary to be closely related to an intellectual disability or to require treatment similar to that required for individuals with intellectual disabilities, which disability originates before the individual attains age eighteen, which has continued or can be expected to continue indefinitely, and which constitutes a substantial limitation to the individual.⁸⁷

I/DD is not a mental illness, but people with I/DD can also have a mental illness.⁸⁸ Mental illness occurs in 5 percent of the general population and mental illness occurs in 5 percent to 8 percent of people with I/DD.⁸⁹

In 2009 there were approximately 80,483 people with I/DD in Washington and 37,545 people were determined eligible for services by

⁸⁵ *Services*, VERA INST. OF JUSTICE, <http://www.vera.org/services> (last visited Mar. 6, 2013).

⁸⁶ Rosa’s Law, Pub. L. No. 111-256, 124 Stat. 2643 (2010) (altering the language in all federal law from the phrase “mental retardation” to the phrase “intellectual disability”). On October 5, 2010, President Obama signed Rosa’s Law, making a simple but monumental change in the language used to refer to individuals with disabilities. This language is seen as less stigmatizing and more respectful. *See id.*

⁸⁷ WASH. REV. CODE § 71A.10.020 (1998).

⁸⁸ MALTMAN, *supra* note 51, at 12.

⁸⁹ *Id.*

DDD. However, only 24,762 people “get a paid DDD service.”⁹⁰ As of May 2011, the known prevalence of I/DD in Washington DOC facilities was thirty-one out of 17,000 inmates.⁹¹

2. Traumatic Brain Injury

The Center for Disease Control (CDC) defines a traumatic brain injury (TBI) as “a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.”⁹² Not all blows or jolts to the head result in TBI.⁹³ The severity of a brain injury may range from “mild,” with a brief change in mental status or consciousness, to “severe,” with an extended period of unconsciousness or amnesia after the injury.⁹⁴

RCW 74.31.010 defines TBI as follows:

Mean[ing] injury to the brain caused by physical trauma resulting from, but not limited to, incidents involving motor vehicles, sporting events, falls, and physical assaults. . . . A traumatic brain injury shall be of sufficient severity to result in impairments in one or more of the following areas: Cognition; language memory; attention; reasoning; abstract thinking; judgment; problem solving;

⁹⁰ *Id.* at 5. The Division of Developmental Disabilities (DDD) provides services that are provided according to individuals’ needs. Services include adult family homes, alternative living services, community protection programs, companion homes, dental services, early support for infants and toddlers, employment and day program services, group homes, home- and community-based service waivers, individual and family service programs, intermediate care facilities for individuals with intellectual disabilities, Medicaid personal care, medically intensive children’s programs, mental health programs, residential habilitation centers, state supplementary payment programs, supported living services, state-operated living alternatives, and voluntary placement services. More information about these services is available at *Division of Developmental Disabilities – Services Provided*, WASH. STATE DSHS, <http://www.dshs.wa.gov/ddd/services.shtml> (last updated Oct. 10, 2012).

⁹¹ Interview with Wash. Dep’t of Corr. Official, Dep’t. of Corr. Headquarters, in Lacey, Wash. (May 2011).

⁹² See *Traumatic Brain Injury*, CTR. FOR DISEASE CONTROL, <http://www.cdc.gov/TraumaticBrainInjury/> (last visited Feb. 21, 2011).

⁹³ *Id.*

⁹⁴ *Id.*

sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; or information processing. The term does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma.⁹⁵

Many people with TBI may experience a multitude of cognitive, emotional, and behavioral symptoms.⁹⁶ For example, attention deficit and memory loss may affect cognitive functions. Personality changes are common.⁹⁷ Those who were previously calm and controlled might become quick-tempered and impulsive.⁹⁸ In some people, anger erupts into aggressive attacks on others.⁹⁹ Many with severe brain injury lack the ability to control their thoughts, emotions, impulses, and conduct.¹⁰⁰ They may become uninhibited, promiscuous, anxious, paranoid, or violent.¹⁰¹ It is because of this lack of ability to control their impulses and conduct that people with TBI may pose a threat to others or themselves.¹⁰²

National estimates indicate that about 2 percent of the US population lives with long-term or lifelong TBI-related disabilities.¹⁰³ Specifically in Washington, from 2002 to 2006, an estimated thirty thousand people sustained a TBI each year, and, during that four year period, 1,300 people reported TBI-related deaths and 5,500 people reported TBI-related hospitalizations.¹⁰⁴

TBI is prevalent in jails and prisons. In 2008, Congress's concern with

⁹⁵ WASH. REV. CODE § 74.31.010 (2007).

⁹⁶ William J. Winslade, *Traumatic Brain Injury and Criminal Responsibility*, 10 LAHEY CLINIC MED. ETHICS 4 (2003).

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ See David J. Thurman et al., *Traumatic Brain Injury in the United States: A Public Health Perspective*, 14 J. HEAD TRAUMA REHAB. 602, 612 (1999).

¹⁰⁴ MALTMAN, *supra* note 51.

the prevalence of TBI in jails and prisons resulted in a mandate that the CDC make this a priority issue.¹⁰⁵ Researchers found that 25 percent to 87 percent of inmates report having experienced a head injury or TBI, as compared to 8.5 percent in the general population.¹⁰⁶ Additionally, the CDC found that (1) inmates who reported head injuries are more likely to have disciplinary problems during incarceration; (2) inmates with head injuries may have seizures or mental health problems such as anxiety or suicidal thoughts and/or attempts; (3) inmates with one or more head injuries have significantly higher levels of alcohol and/or drug use during the year preceding their current incarceration; (4) inmates with undiagnosed TBI presented a greater risk of injuring corrections staff; and (5) inmates with memory deficits due to TBI have a more difficult time understanding or remembering rules or directions.¹⁰⁷

Screening for TBI in prisons has been recommended as a means of implementing more effective substance abuse treatment¹⁰⁸ and inmate management¹⁰⁹ within correctional facilities. Results from a recent Minnesota project¹¹⁰ suggest that a routine intake question asking if the inmate ever had a head injury was inadequate in identifying an incident leading to TBI.¹¹¹ Though simply asking whether an inmate ever suffered a head injury may be inadequate, more extensive screening may prove more effective.

As a result of the CDC's commitment to TBI, the CDC has led the way in

¹⁰⁵ Traumatic Brain Injury Act of 2008, Pub. L. No. 110-206, 122 Stat. 714 (2008).

¹⁰⁶ Marlena M. Wald et al., *Traumatic Brain Injury Among Prisoners*, 5 BRAIN INJURY PROF. 1, 22 (2008), available at <http://www.brainline.org/downloads/PDFs/Traumatic%20Brain%20Injury%20Among%20Prisoners.pdf>.

¹⁰⁷ U.S. CTR. FOR DISEASE CONTROL, TRAUMATIC BRAIN INJURY IN PRISONS AND JAILS: AN UNRECOGNIZED PROBLEM 1-2 (2006), available at http://www.cdc.gov/traumaticbraininjury/pdf/Prisoner_TBI_Prof-a.pdf.

¹⁰⁸ Wald et al., *supra* note 104, at 101.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ *Id.*

developing screening for TBI. Screening tools have been developed specifically for use with incarcerated populations.¹¹² For example, Ohio State University's Traumatic Brain Injury Identification Method is a standardized procedure for eliciting lifetime history of TBI.¹¹³ This method has been validated, and several variations of this screening tool have been developed.¹¹⁴ The validity is not based on an accounting of a person's lifetime history of TBI;¹¹⁵ instead, this data is used to indicate the likelihood that consequences have resulted from exposure to TBI. One version has proven useful in jail and prison settings as it can be completed in less than twenty minutes.¹¹⁶ This tool can be used as a preventative measure to help an inmate keep out of trouble before an event occurs and to increase the safety of correctional personnel.¹¹⁷

3. Special Needs for Women

The differences between men and women are relevant to institutional classification systems. Researchers have identified relevant risk factors for women during incarceration, including marital status, suicide attempts, family structure of childhood home, child abuse, depression, substance abuse, single parenting, reliance on public assistance, dysfunctional

¹¹² See *id.* at 24.

¹¹³ Jennifer Bogner & John D. Corrigan, *Reliability and Predictive Validity of the Ohio State University TBI Identification Method with Prisoners*, 24 J. HEAD TRAUMA REHAB. 279, 282 (2009); Interview with John Corrigan, M.D., Ohio Valley Ctr. for Brain Injury Prevention and Rehab. (Sept. 2, 2011). See generally *Ohio Valley Center for Brain Injury Prevention and Rehabilitation*, OHIO VALLEY CTR. FOR BRAIN INJURY PREVENTION AND REHAB., <http://ohiovalley.org> (last visited Oct. 22, 2012).

¹¹⁴ *Screening for TBI: A Snapshot from OVC*, OHIO VALLEY CTR. FOR BRAIN INJURY PREVENTION AND REHAB., <http://ohiovalley.org/informationeducation/synapshots/screening/> (last visited Oct. 11, 2012).

¹¹⁵ *Id.*

¹¹⁶ Bogner & Corrigan, *supra* note 111.

¹¹⁷ *Id.*

relationships, and prison homosexual relationships.¹¹⁸

Responding to the substantial increase in the number of incarcerated women, the National Institute of Corrections (NIC), the Center for Criminal Justice Research, and the Institute on Crime, Justice, and Corrections worked together to improve the objective classifications for women offenders.¹¹⁹

The American Bar Association (ABA) Criminal Justice Section, passed Resolution 105C urging all correctional facilities to “develop and implement gender-responsive needs assessments that account for women’s specific needs, including parenting responsibilities, the importance of their relationships, their histories of domestic violence and abuse, and their distinctive patterns and prevalence of mental health issues.”¹²⁰ Among other things, the recommendation was based upon a research study done by the University of Cincinnati. The study demonstrated that “women have unique characteristics and needs that can and should be addressed by the criminal justice system.”¹²¹

Facilities should utilize a gender-specific assessment for women.¹²² Neither the Washington DOC nor local jails utilize a separate assessment for women entering the correctional system. The National Institute of Corrections has developed an assessment specifically for incarcerated women, and offers free trainings to correctional institutions.¹²³ The NIC offers free individualized orientation and consulting sessions to agencies

¹¹⁸ PATRICIA L. HARDYMAN & PATRICIA VAN VOORHIS, U.S. DEP’T OF JUSTICE & NAT’L INST. OF CORR., DEVELOPING GENDER-SPECIFIC CLASSIFICATION SYSTEMS FOR WOMEN OFFENDERS 4 (2004), *available at* <http://static.nicic.gov/Library/018931.pdf>.

¹¹⁹ *Id.* at vii.

¹²⁰ A.B.A. SECT. CRIM. JUST., RESOLUTION 105C REPORT TO THE HOUSE OF DELEGATES (2011), *available at* <http://www.americanbar.org> (search “Resolution 105c 2011” then select “2011_hod_annual_meeting_105c”).

¹²¹ *Id.*

¹²² *See* HARDYMAN & VOORHIS, *supra* note 115, at 4.

¹²³ *See Women Offenders*, NAT’L INST. OF CORR., <http://www.nicic.gov/womenoffenders> (last visited Aug. 15, 2011).

interested in learning more about the Women's Risk Needs Assessment.¹²⁴

Currently there are two women's prisons in Washington: the Washington Corrections Center for Women (WCCW) and the smaller Mission Creek Corrections Center for Women. The superintendents at both of these facilities are women.

At WCCW, there have been two encouraging changes within the last year. For one, a new policy was instituted that provides for mental health counselors to stay with their patients when the women move between mental health units¹²⁵—this is significant for continuity of care. Second, serious consideration is being given by DOC officials to include Therapeutic Community concepts in the mental health unit.¹²⁶

III. SOLITARY CONFINEMENT AND ITS USE FOR PEOPLE WITH MENTAL DISABILITIES

While precise data on nationwide utilization of solitary confinement is unknown, we do know that some twenty thousand inmates are in solitary confinement in US "supermax" prisons and that tens of thousands more are held in isolation in other prisons and jails.¹²⁷ The increased use of solitary confinement raises the question of whether it is an effective and humane use of scarce public resources. Many in the legal and medical fields criticize solitary confinement as unconstitutional and inhumane, pointing to the well-

¹²⁴ See *Technical Assistance*, NAT'L INST. CORR., <http://nicic.gov/TA> (last visited Oct. 22, 2012).

¹²⁵ Interview with Jane Parnell, Superintendent, Wash. Corr. Ctr. for Women, in Gig Harbor, Wash. (Sept. 15, 2011).

¹²⁶ Therapeutic Communities are a well-established treatment modality used both in community and incarcerated settings. Peer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop social skills. The model can be adapted for various settings and populations. See GEORGE DELEON, *THE THERAPEUTIC COMMUNITY: THEORY, MODEL AND METHOD* (2000).

¹²⁷ See generally Alexandra Naday et al., *The Elusive Data on Supermax Confinement*, 88 PRISON J. 69 (2008) (examining Supermax facilities in the United States).

known harms associated with placing human beings in isolation.¹²⁸

A. What Is Solitary Confinement?

Solitary confinement is the practice of placing a person alone in a cell for twenty-two to twenty-four hours a day with little human contact or interaction, reduced or no natural light, severe constraints on visitation and participation in group activities, and reduced or no access to reading material, television, radios, or other property.¹²⁹ Human contact is generally restricted to brief interactions with corrections officers.¹³⁰ While some prisoners may have occasional encounters with health care providers or attorneys, the DOC limits family visits.¹³¹ Furthermore, almost all human contact occurs while the prisoner is in restraints and behind some sort of barrier.¹³² Inmates often refuse visits, especially from family, due to the humiliation associated with these DOC restraint policies.

B. Use of Solitary Confinement in Washington State

The Washington DOC has several categories of solitary confinement beds. First, the intensive management unit (IMU) is designed for inmates on death row and “those inmates deemed to present an immediate and serious threat to the security and safety of the facility, staff, self, and/or other offenders.”¹³³ The DOC considers serious threats to include serious

¹²⁸ ACLU, ACLU BRIEFING PAPER: THE DANGEROUS OVERUSE OF SOLITARY CONFINEMENT IN THE UNITED STATES 1, available at http://www.aclu.org/files/pdfs/prison/stop_solitary_briefing_paper.pdf (last visited Jan. 30, 2013) [hereinafter ACLU BRIEFING PAPER]. See, e.g., ACLU, STOP SOLITARY—THE DANGEROUS OVERUSE OF SOLITARY CONFINEMENT IN THE UNITED STATES, available at <http://www.aclu.org/stop-solitary-dangerous-overuse-solitary-confinement-united-states> (last visited Feb. 20, 2012).

¹²⁹ See COHEN, *supra* note 9, § 11.1.

¹³⁰ *Id.*

¹³¹ See *id.* § 11.1–11.2.

¹³² See *id.*

¹³³ Letter from Wash. Dep’t of Corr. to author (Aug. 30, 2011) (on file with author).

infractions, chronic behavior or infraction problems, and acts that present a specific risk, like escape attempts, threats, or affiliation with a particular group.¹³⁴ As of October 2012, there were seven inmates on death row.¹³⁵ The number of inmates with mental disabilities in solitary confinement is unknown as the DOC does not track this information.¹³⁶

Second, an offender may be assigned to solitary confinement when he or she (1) poses a threat to self, staff, other offenders, property, or to the orderly operation of the facility; (2) requests protection or is deemed by staff to require protection; (3) is pending transfer or is in transit to a more secure facility; (4) poses a serious escape risk; or (5) is the subject of a pending investigation.¹³⁷

Third, the infirmary unit has a close-observation area.¹³⁸ The offenders in this unit are mentally ill.¹³⁹ They are in need of acute care and are located in the infirmary unit due to being on “suicide watch” or for psychiatric observation.¹⁴⁰

Finally, the special offender unit has the intensive treatment unit. These beds are for maximum-custody mentally ill offenders on intensive treatment status.¹⁴¹ The total segregation capacity in men’s prisons allow for 1,015

¹³⁴ *Id.*

¹³⁵ *Offenders Sentenced to the Death Penalty*, WASH. DEP’T OF CORR., <http://www.doc.wa.gov/offenderinfo/capitalpunishment/sentencedlist.asp> (last visited Oct. 12, 2012).

¹³⁶ Interview with Staff Members, Wash. Dep’t of Corr., in Lacey, Wash. (August, 2011).

¹³⁷ Letter from Dept of Corr. Official, Wash. Dep’t of Corr. to author (Aug. 30, 2011) (on file with author).

¹³⁸ Personal observation by fellow at Monitoring Facilities (Oct. 2010 – June 2011).

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ Interview with Staff Members, Wash. Dep’t of Corr., Monroe Corr. Ctr., in Monroe, Wash. (October 2010); Personal observations by fellow, Monroe Corr. Ctr., in Monroe, Wash. (May 16, 2012, June 24, 2012).

inmates.¹⁴²

C. People with Mental Illness and Solitary Confinement

People with mental disabilities are likely to be placed in solitary confinement due to an inability to follow prison rules and regulations.¹⁴³ The use of solitary confinement costs twice as much as other levels of confinement.¹⁴⁴

People with mental illness, I/DD, and TBI often have a difficult time understanding and complying with the rules and regulations in prison. As a result, they tend to receive infractions that result in solitary confinement at a more frequent rate than the general prison population.¹⁴⁵ They are often kept longer for infractions related to their disabilities, such as head-banging, suicide attempts, and self-cutting.¹⁴⁶

Prisoners exhibit a variety of negative physiological and psychological reactions to solitary confinement. These impacts have even risen to the level of constitutional violations in some cases.¹⁴⁷ There is agreement among many mental health experts that long-term solitary confinement is psychologically harmful, even to persons with no prior history of mental

¹⁴² Interview with Staff Members, Wash. Dep't of Corr., Monroe Corr. Ctr., in Monroe, Wash. (Oct. 2010); Personal observations by fellow, Monroe Corr. Ctr., in Monroe, Wash. (May 16, 2012, June 24, 2012).

¹⁴³ *Id.*

¹⁴⁴ JOHN J. GIBBONS & NICHOLAS DE B. KATZENBACH, CONFRONTING CONFINEMENT: A REPORT OF THE COMMISSION ON SAFETY AND ABUSE IN AMERICA'S PRISONS 15 (2006), available at http://www.vera.org/download?file=2845/Confronting_Confinement.pdf.

¹⁴⁵ Interview with Staff Members, Wash. Dep't of Corr., Monroe Corr. Ctr., in Monroe, Wash. (Oct. 2010); Personal observations by fellow, Monroe Corr. Ctr., in Monroe, Wash. (May 16, 2012, June 24, 2012).

¹⁴⁶ Interview with Staff Members, Wash. Dep't of Corr., Monroe Corr. Ctr., in Monroe, Wash. (Oct. 2010); Personal observations by fellow, Monroe Corr. Ctr., in Monroe, Wash. (May 16, 2012, June 24, 2012).

¹⁴⁷ See, e.g., *Austin v. Wilkinson*, 545 U.S. 209 (2005); *In re Medley*, 134 U.S. 160, (1890); *Madrid v. Gomez*, 889 F. Supp. 1146, 1265–66 (N.D. Cal. 1995).

illness.¹⁴⁸ The side effects are so well recognized that they have become known as “special housing unit syndrome.”¹⁴⁹ Prisoners in solitary confinement are believed to engage in self-mutilation at rates higher than the general population.¹⁵⁰ Solitary confinement has been identified as a major factor in suicidal ideation and suicide attempts.¹⁵¹ It is not unusual for prisoners in solitary confinement to compulsively cut their flesh, repeatedly smash their heads against walls, swallow razors and other harmful objects, or attempt to hang themselves.¹⁵² Federal courts have even considered whether placing severely mentally ill inmates in solitary confinement amounts to cruel and unusual punishment in violation of the Eighth Amendment of the US Constitution.¹⁵³

Further, the long term effects of solitary confinement are troubling. A study following Washington State inmates during the first year following their releases from prison found that individuals were more likely to commit felonies and crimes against other people if they had been assigned to a supermax facility while incarcerated.¹⁵⁴ The Commission on Safety and Abuse in America’s Prisons found that the “increasing use of high-security segregation is counter-productive, often causing violence inside facilities

¹⁴⁸ See Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 J. L. & POL’Y 325, 328–29 (2006); Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. L. & SOC. CHANGE 477, 530–33 (1997).

¹⁴⁹ See Grassian, *supra* note 146, at 334.

¹⁵⁰ See Haney & Lynch, *supra* note 146, at 518, 525.

¹⁵¹ ILDIKO SUTO, INMATES WHO ATTEMPTED SUICIDE IN PRISON: A QUALITATIVE STUDY 23 (2007), available at <http://commons.pacificu.edu/cgi/viewcontent.cgi?article=1061&context=spp>.

¹⁵² See Haney & Lynch, *supra* note 146, at 518.

¹⁵³ See *Estelle v. Gamble*, 429 U.S. 97 (1976).

¹⁵⁴ DAVID LOVELL & CLARK JOHNSON, FELONY AND VIOLENT RECIDIVISM AMONG SUPERMAX PRISON INMATES IN WASHINGTON STATE: A PILOT STUDY 14 (2004), available at <http://www.son.washington.edu/faculty/fac-page-files/Lovell-SupermaxRecidivism-4-19-04.pdf>.

contributing to recidivism after release.”¹⁵⁵ The Commission recommended that prison administrators take the following steps: “(1) make segregation a last resort . . . and stop releasing people directly from segregation to the streets; (2) end conditions of isolation and ensure that segregated prisoners have regular and meaningful human contact; and (3) protect mentally ill prisoners.”¹⁵⁶ In recognition of the inherent problems of solitary confinement, the ABA recently approved standards to reform its use.¹⁵⁷

Professor Vincent M. Nathan, who has acted as a consultant for the US Department of Justice (DOJ) in several investigations, testified that “all types of segregation carry with them a level of control that is punitive in effect if not in intent.”¹⁵⁸ Serving time under these conditions is exceptionally difficult and takes a toll on mental health, particularly if the victim has a prior history of mental illness.¹⁵⁹ Studies confirm that psychological distress increases with the degree of restriction in segregation.¹⁶⁰

Numerous studies have acknowledged the harmful effects of isolation, particularly for mentally ill inmates. One lone study, however, concluded otherwise. The Colorado DOC recently released the controversial results of a year-long study, One Year Longitudinal Study of the Psychological Effects of Administrative Segregation, which was federally funded and conducted at the Colorado State Penitentiary (a supermax facility).¹⁶¹ Although this study concluded that solitary confinement does not cause

¹⁵⁵ GIBBONS & KATZENBACH, *supra* note 142, at 14.

¹⁵⁶ *Id.*

¹⁵⁷ ACLU BRIEFING PAPER, *supra* note 126, at 1.

¹⁵⁸ NAT’L PRISON RAPE ELIMINATION COMM’N REPORT, *supra* note 16, at 79.

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ See MAUREEN L. O’KEEFE ET AL., DEP’T OF PSYCHOLOGY, UNIV. OF COLO., ONE YEAR LONGITUDINAL STUDY OF THE PSYCHOLOGICAL EFFECTS OF ADMINISTRATIVE SEGREGATION (2010), available at <https://www.ncjrs.gov/pdffiles1/nij/grants/232973.pdf>.

harm to mentally ill inmates,¹⁶² this study contradicts considerable previous research and prevailing expert opinion, and several experts have expressed grave concerns about the research methodology.¹⁶³ Therefore, despite the results of the Colorado study, it is widely accepted that solitary confinement is harmful to inmates who suffer from mental illness.

D. Conditions of Solitary Confinement in the Washington Department of Corrections

Mentally ill inmates in Washington prisons are subject to solitary confinement too frequently. Two studies conducted in Washington State provide a survey of mentally ill prisoners in solitary confinement. The first study looked at 232 male inmates in Washington's IMU during 1999.¹⁶⁴ At that time, serious mental illness had been an official component of Washington's inmate classification for only three years.¹⁶⁵ Compared to all Washington prisoners, IMU residents were younger, had been convicted of more violent offenses, had much longer prison sentences, and had much

¹⁶² *Id.* at viii–ix.

¹⁶³ See generally STUART GRASSIAN & TERRY KUPERS, THE COLORADO STUDY VS. THE REALITY OF SUPERMAX CONFINEMENT 1 (2011), available at www.probono.net/prisoners/stopsol-reports/attachment.212211. See also *ACLU and Experts Slam Findings of Doc Report on Solitary Confinement*, ACLU OF COLO. (Nov. 29, 2010), <http://aclu-co.org/news/aclu-and-experts-slam-findings-of-doc-report-on-solitary-confinement>.

Dr. Terry Kupers, one of the world's leading experts on the psychological effects of solitary confinement notes that "the methodology of the study is so deeply flawed that I would consider the conclusions almost entirely erroneous the researchers did not even spend time talking to the subjects about their experiences in supermax . . . far from finding 'no harm,' there was many episodes of psychosis and suicidal behavior during the course of the study." Dr. Grassian, another expert, commented "the study is flawed." He says they methodology has a "fatal flaw."

Id.

¹⁶⁴ David Lovell et al., *Who Lives in Super-Maximum Custody? A Washington State Study*, 64 FED. PROBATION 33, 33–38 (2000).

¹⁶⁵ *Id.*

higher rates of major infractions.¹⁶⁶

A second study reported results of a systematic survey of the clinical status of supermax residents. This study used data collected during 1999 and 2001, and focused on 131 inmates who were randomly selected from Washington's supermax facilities.¹⁶⁷ The study concluded that 45 percent of supermax residents have serious mental illness, marked psychological symptoms, a history of psychological breakdowns, or brain damage.¹⁶⁸ The study suggested that greater flexibility in prison classification and discipline procedures be established, especially those that determine how long prisoners stay in supermax.¹⁶⁹ Following the study, a committee was formed to design a program for "behavioral disturbed prisoners."¹⁷⁰ Yet the program was never established.

While DOC regulations provide that disability status should be considered in determining the appropriate sanction for infractions,¹⁷¹ in practice, this means that although the inmate may receive less punishment as a result of the "infraction," the inmate will still be punished and will have an infraction on his or her record. The punishment is likely to include solitary confinement. While in solitary, "good time" stops,¹⁷² programming and education is extremely limited, and employment opportunities are virtually non-existent. Research suggests that academic and vocational programs are associated with lower recidivism and better employment

¹⁶⁶ *Id.*

¹⁶⁷ David Lovell, *Patterns of Disturbed Behavior in a Supermax Population*, 35 CRIM. JUST. & BEHAV. 987 (2008).

¹⁶⁸ *Id.*

¹⁶⁹ *See id.* at 995–94.

¹⁷⁰ *Id.* at 985.

¹⁷¹ WASH. ADMIN. CODE § 137-28-360 (1995).

¹⁷² "Good time," often referred to as "time off for good behavior," results in a reduced sentence for inmates who maintain good behavior while incarcerated. *See generally* WASH. DEP'T OF CORR., EARNED RELEASE TIME POLICY (2012), available at <http://www.doc.wa.gov/policies/showFile.aspx?name=350100>.

opportunities after release.¹⁷³ Therefore, being placed in solitary confinement may actually increase an inmate's chances of returning to prison after release. Additionally, inmates with mental disabilities are likely to receive further infractions, leading to more time in solitary, or to be charged with "persistent prison misbehavior,"¹⁷⁴ as specified in a law passed by the Washington legislature in 1995. This law states that some infractions, other than class A or class B felonies, can be labeled as crimes, and are punishable by as much as an additional five years in prison if an inmate knowingly commits a serious infraction.¹⁷⁵

E. Cost of Solitary Confinement

Almost no research suggests that solitary confinement is efficient as a prison management tool, and evidence suggests that it is the most expensive form of incarceration.¹⁷⁶ There are multiple reasons for this increased cost, including higher staffing costs—"prisoners are usually required to be escorted by two or more officers any time they leave their cells"¹⁷⁷ and "work assignments typically performed by prisoners, such as cooking and cleaning, must be done by paid staff."¹⁷⁸ The costs of housing general population prisoners as compared to prisoners held in solitary illustrate the costs differentials.¹⁷⁹ In response to this cost differential, efforts have been made across the nation to reduce costs, and consequentially the use of solitary confinement.¹⁸⁰

In recent years, Mississippi, Texas, and Illinois have decreased the number of inmates in solitary confinement: a "dramatic acknowledgement,

¹⁷³ NAT'L PRISON RAPE ELIMINATION COMM'N REPORT, *supra* note 16, at 80.

¹⁷⁴ WASH. REV. CODE § 9.94.070(2) (1995).

¹⁷⁵ *Id.*

¹⁷⁶ ACLU BRIEFING PAPER, *supra* note 126, at 7.

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ *See infra*, notes 182–185.

analysts say, that states can no longer sustain the costs of hardline criminal justice policies.”¹⁸¹ In a response “spurred by federal lawsuits over deteriorating prison conditions, Mississippi officials sharply reduced solitary confinement numbers in the past several years from nearly 1,000 to about 150.”¹⁸² Texas’s plan to add drug rehabilitation beds resulted in a reduction in the solitary confinement population from 9,343 to 8,627,¹⁸³ and Illinois recently reduced segregated offenders from 2,266 to 347.¹⁸⁴ Washington has recently contacted the Vera Institute¹⁸⁵ for assistance with inmates with mental disabilities in solitary confinement. In addition to developing and implementing more humane policies, Washington, like other states, would most likely save money by reducing the use of solitary for people with mental disabilities.

Unfortunately, despite these national trends, all states still subject inmates to supermax conditions.

IV. ADDRESSING FISCAL CONCERNS, OVERSIGHT SHORTCOMINGS, AND COMMUNICATION FAILURES

National and international standards, court rulings, expert reports, and testimony provide guidance on proper care for inmates. What appears to be lacking, then, is not knowledge of what to do, but the commitment and resources to provide adequate treatment.

First, this section identifies the most commonly expressed concerns for

¹⁸¹ Kevin Johnson, *States Start Reducing Solitary Confinement to Help Budgets*, USA TODAY, (June 13, 2010), http://usatoday30.usatoday.com/news/nation/2010-06-13-solitary-confinement-being-cut_N.htm (last updated June 14, 2010).

¹⁸² *Id.*

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ Vera Institute is a nonprofit organization that works closely with government. Projects and reform initiatives are typically conducted in partnership with local, state, or national offices. See generally *About Us*, VERA, <http://www.vera.org/content/about-us> (last visited Oct. 14, 2012).

providing adequate mental health care to the incarcerated population: fiscal concerns. Second, this section identifies two other concerns: lack of external oversight of the DOC and lack of communication regarding I/DD, TBI, and mental illness in the jail and prison system. Finally, this section addresses another major concern: the high rate of the use of solitary confinement for those inmates with I/DD, TBI, or mental disabilities.

A. Acknowledging Fiscal Concerns

Washington State, like many other states, is facing financial challenges. The cost of hospitalization is generally more expensive than incarceration.¹⁸⁶ However, this does not take into consideration the added costs of crime, which include (1) the crime committed; (2) the arrests and booking; (3) the court proceedings costs (i.e., public defenders, prosecutors, judges, court clerks); (4) the possible competency evaluation; and (5) the jails and, if convicted, the DOC. Additional costs include harm caused to the victim, possible mental deterioration of the defendant, and monetary costs to the taxpayer.¹⁸⁷

B. Lack of Correctional Oversight

The United States is one of the only Western countries without a formal and comprehensive system in place for the routine, external review of all prisons and jails. Oversight provides for transparency of public institutions

¹⁸⁶ Scot Nakagawa, *Prisons Are the New Mental Hospitals*, P'SHIP FOR SAFETY & JUSTICE (Apr. 14, 2004), <http://www.safetyandjustice.org/node/237>.

¹⁸⁷ See *id.* Community programs provide an array of services, such as housing, counseling, medication management, support groups, and other appropriate services. As indicated by the name, they are provided in the community where the client lives. One example includes sentences being waived by the court if eligible offenders participate in twelve months of community service and complete a treatment program that is supervised by a community corrections officer. See, e.g., *Alternatives to Total Confinement for Some Parents of Minor Children*, WASH. DEP'T OF CORR., <http://www.doc.wa.gov/community/fosa/default.asp> (last visited Oct. 22, 2012).

and accountability for the operation of safe and humane prisons and jails. Otherwise, inmates are at risk of becoming an invisible population. A national consensus exists that expanded external oversight of prisons and jails in the United States would be valuable and is needed.¹⁸⁸

C. Inadequate Communication Regarding Mental Health, Medications, and Medical Conditions Upon Entering a Correctional Facility

When an inmate enters a correctional facility for the first time it is essential to identify the inmate's mental health needs, particularly if medications are involved. Current mental health assessments done upon arrival are inadequate for a variety of reasons. For example, some inmates entering jail may be intoxicated or otherwise unable to participate in these assessments. In prisons, inmates often do not answer questions honestly for fear of the stigma associated with being labeled mentally disabled and for fear of losing privileges, such as visitors.¹⁸⁹

Furthermore, while family members and community health providers often have vital information about those who are incarcerated, such as medications and mental health history, it is difficult, if not impossible, for them to contact the appropriate official in many jails or prisons.

In 2010, DOC adopted a new formulary for permitted medication in the prison system. Many inmates said they were given new medications that did not work or that caused significant side effects.¹⁹⁰ Some inmates reported

¹⁸⁸ See Stephen J. Saltzburg, *Report to the House of Delegates*, A.B.A., SEC. CRIM. JUST. (2008), available at http://www.americanbar.org/content/dam/aba/publishing/criminal_justice_section_newsletter/crimjust_policy_am08104b.authcheckdam.pdf; Michele Deitch, *Conference Report: Opening Up a Closed World: What Constitutes Effective Prison Oversight?*, XVIII CORRECTIONAL L. REP. 22 (Aug.–Sept. 2006); Michele Deitch, *Independent Correctional Oversight Mechanisms Across the United States: A 50-State Inventory*, 30 PACE L. REV. 1762 (2010).

¹⁸⁹ Interviews with Inmates, Monroe Corr. Complex, in Monroe, Wash. (Oct. 2010–June 2011).

¹⁹⁰ *Id.*

that they stopped their medications due to the adverse side effects.¹⁹¹

In interviews, the author heard expressions of frustration among jail administrators that the DOC often does not want inmate medical records and that DOC will not accept the seven days of medication the jails prepare when an inmate is being released from its facility.¹⁹² The DOC also informed the author that it would prefer a one page medical summary instead of the complete medical record of each inmate.¹⁹³ The DOC will not accept medications because of different formula regimes (some jails have adopted DOC formulas but others have not)¹⁹⁴

This lack of continuity can result in an inmate deprived of medication for two or three days upon entering a DOC facility. In addition, there is no consistency among the jails in the sharing of accumulated information regarding the disability accommodation needs and disability-related vulnerabilities of an inmate. In two systems where there is such frequent interaction, the systems must be coordinated to be mutually intelligible and thereby provide a smooth transition for an inmate who is transitioning from one system to the other.

Conditions in prison for inmates with mental health problems are especially grim. For example, “inmates who [have] a mental health problem (24 percent) were three times as likely as jail inmates without (8 percent) to report being physically or sexually abused in the past.”¹⁹⁵ Also, state prisoners who had mental health problems were twice as likely as state prisoners without mental health problems to have been injured in a fight

¹⁹¹ Interviews with Inmates, Monroe Corr. Facility, in Monroe, Wash. (May 16, 2011, June 24, 2011); Interviews with Inmates, Wash. Corr. Complex for Women, in Gig Harbor, Wash. (May 26, 2011).

¹⁹² Interviews with Wash. Dep’t of Corr. Staff, Wash. Corr. Ctr., in Shelton, Wash. (Mar. 2011).

¹⁹³ *Id.*

¹⁹⁴ *Id.*

¹⁹⁵ JAMES & GLAZE, *supra* note 17, at 1.

since admission (20 percent compared to 10 percent).¹⁹⁶

Costs are often cited as the primary barrier to treatment. Hospitalization is more expensive than incarceration,¹⁹⁷ but this ignores many side-effect costs of incarceration. Many less expensive alternatives exist, such as community diversion options, housing, and community programs.¹⁹⁸

V. ADDRESSING THE PROBLEMS IN JAILS AND PRISONS FOR INCARCERATED INDIVIDUALS WITH I/DD, TBI, AND SERIOUS MENTAL ILLNESS

Jails and prisons are not equipped to respond to people with mental illness. The environments are inappropriate, and the staff is not trained properly.

Offenders with mental illness are “frequent flyers,” a term used to describe recidivists. This is because most people with mental illness leaving jails and prisons receive little, if any psychiatric aftercare.¹⁹⁹

Across Washington, there is a growing frustration with the lack of resources within these institutions to provide the most appropriate release plan for those with mental illness. Additionally, there is equal frustration with the lack of community resources for inmates upon their release. Even when there is an appropriate release plan, inmates often have difficulty maintaining medication or keeping appointments without appropriate community support.

Three main problems contribute to this frustration: inmates with mental illnesses cost more, stay incarcerated longer, and present major

¹⁹⁶ *Id.*

¹⁹⁷ See E. FULLER TORREY, M.D. ET AL., MORE MENTALLY ILL PERSONS IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES (2010), *available at* http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

¹⁹⁸ See JOHN HOWARD SOC’Y OF ALTA., COMMUNITY CORRECTIONS (1998), *available at* <http://www.johnhoward.ab.ca/pub/C29.htm>.

¹⁹⁹ TORREY ET AL., *supra* note 6, at 9.

management problems. First, inmates cost more because of increased staffing needs, the cost of psychiatric medications,²⁰⁰ the cost of psychiatric examinations, and the cost of an increased number of lawsuits.²⁰¹ Next, inmates with mental illness stay incarcerated longer because it is difficult for them to understand and follow jail and prison rules.²⁰² In one Washington prison study, inmates with mental illness accounted for 41 percent of infractions even though they constituted only 19 percent of the prison population.²⁰³

Finally, inmates with mental illness present major management problems because of impaired cognitive, learning, and problem-solving abilities, and this often prompts extended time in solitary confinement. As a point of reference, in Wisconsin, a 2010 audit of three state prisons reported that “between 55 percent and 76 percent of inmates in segregation (isolation) are mentally ill.”²⁰⁴

VI. USING EXISTING LEGAL MECHANISMS TO ADDRESS AND REMEDY INJUSTICE.

Professionals in Washington can and should look to existing legal standards when reconsidering the policies and practices of jails and prisons. All incarcerated people, particularly those with mental disabilities, are legally protected from abuse under the law. Unfortunately, these rights are not always enforced. However, litigation continues to be a successful tool to protect the rights of people incarcerated. This section, first, briefly addresses existing federal legal resources that could help in the fight to increase awareness of inmate mistreatment including the US Constitution, the Civil Rights of Institutionalized Persons Act, and the Americans with

²⁰⁰ *Id.* at 9–10.

²⁰¹ *Id.* at 10.

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.*

Disabilities Act. Second, this section notes advances in Washington case law and examines recent Washington legislative action.

A. The US Constitution

While the US Constitution does not contain any explicit provisions that refer to the treatment of prisoners, certain rights can be imputed.²⁰⁵ The primary constitutional protection for prisoners is the Eighth Amendment prohibition of “cruel and unusual punishment.”²⁰⁶ It is well established within US constitutional jurisprudence that the Eighth Amendment requires prison officials to provide prisoners with such basic needs such as adequate food and water, shelter, clothing, sanitation, personal safety, and medical care—including mental health treatment.²⁰⁷

B. The Civil Rights of Institutionalized Persons Act

The DOJ may bring civil suits for abuses in state and local jails and prisons that violate the civil rights of prisoners under the Civil Rights of Institutionalized Persons Act (CRIPA).²⁰⁸ Congress passed CRIPA in 1980 to enable the federal government to investigate and pursue civil suits against state institutions that the attorney general suspects of violating the US

²⁰⁵ *Prisons and Prisoner's Rights: An Overview*, LEGAL INFO. INST., http://www.law.cornell.edu/wex/prisoners_rights (last visited Feb. 14, 2012).

Prisoners retain some other constitutional rights, including due process in their right to administrative appeals and a right of access to the parole process. The Equal Protection Clause of the Fourteenth Amendment has been held to apply to prison inmates. Prisoners are therefore protected against unequal treatment on the basis of race, sex, and creed. Additionally, the Model Sentencing and Corrections Act provides that a confined person has a protected interest in freedom from discrimination on the basis of race, religion, national origin, or sex. Prisoners also have limited rights to speech and religion.

Id.

²⁰⁶ U.S. CONST. amend. VIII.

²⁰⁷ *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976).

²⁰⁸ 42 U.S.C. § 1997a(a) (1996).

Constitution.²⁰⁹ In doing so, the DOJ must have a reasonable cause to believe “that a state institution is engaging in a pattern or practice” of subjecting prisoners to “egregious or flagrant conditions” violating the Constitution.²¹⁰

CRIPA has been used to enforce prisoners’ rights in Washington. For example, in 2006, the DOJ notified King County officials of its concerns regarding conditions at the King County Correctional Facility and of its intention to investigate.²¹¹ As a result, King County and the DOJ entered into a memorandum of agreement in November 2009 to address the use of excessive force, the failure to implement suicide prevention measures, and the failure to provide adequate medical care.²¹²

C. The Americans with Disabilities Act

In 1990, Congress passed the Americans with Disabilities Act (ADA) with the intention that it “provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”²¹³ By enacting the ADA, Congress recognized that physical and mental disabilities in no way diminish a person’s right to fully participate in all aspects of society, but that people with physical or mental disabilities are frequently precluded from doing so because of prejudice, antiquated attitudes, or societal and institutional barriers.²¹⁴ The Act bans discrimination against people with disabilities, a category that includes

²⁰⁹ *See id.*

²¹⁰ *Id.*

²¹¹ U.S. DEP’T OF JUSTICE & KING CNTY. WASH., MEMORANDUM OF AGREEMENT BETWEEN THE U.S. DEPARTMENT OF JUSTICE AND KING COUNTY, WASHINGTON CONCERNING THE KING COUNTY CORRECTIONAL FACILITY 1 (2009), *available at* http://www.justice.gov/crt/about/spl/documents/KCCF_MoA_01-14-09.pdf.

²¹² *Id.* at 4–16.

²¹³ 42 U.S.C. § 12101(b)(1) (2009).

²¹⁴ *Id.*

persons with mental illness.²¹⁵

The ADA has also provided additional protection for incarcerated persons. In 1998, the US Supreme Court unanimously held that Title II of the ADA applies to state prisoners.²¹⁶ Title II of the ADA covers services, programs, and activities of any state or local government or their departments, agencies, special purpose districts, and other instrumentalities²¹⁷ when determining whether an inmate with a disability in a state prison may sue the state for money damages.²¹⁸ Title II also creates a private cause of action for damages against states for conduct that *actually* violates the Fourteenth Amendment.²¹⁹ Essentially, the ADA abrogates state sovereign immunity, meaning state employees, who are often granted immunity, can be personally sued for an actual violation of the Fourteenth Amendment.²²⁰

D. Advances in Washington

1. Washington Case Law

There is also precedent in Washington for legal action involving the conditions of confinement. For example, in 2010 the Washington DOC signed a settlement agreement and order in response to a class action suit brought by “women who have been, are, or will be confined by the Washington Department of Corrections.”²²¹ The lawsuit was brought to

²¹⁵ *Id.* § 12101(a)(1).

²¹⁶ Pa. Dep’t of Corr. v. *Yeskey*, 524 U.S. 206, 209 (1998).

²¹⁷ 42 U.S.C. § 12131(1) (2000).

²¹⁸ *Yeskey*, 524 U.S. at 209.

²¹⁹ *United States v. Georgia*, 546 U.S. 151, 159 (2006).

²²⁰ *Id.*

²²¹ *Female Prisoners Settle Lawsuit Against Washington Department of Corrections Challenging Staff Sexual Abuse*, COLUMBIA LEGAL SERVS. & PUB. INTEREST LAW GRP. (PILG) (Aug. 6, 2010), available at <http://www.columbialegal.org/files/JaneDoeSettlementPressRelease.pdf> [hereinafter COLUMBIA LEGAL SERVICES & PILG];

challenge specific acts of sexual assault, as well as systemic failures of the DOC to take the necessary steps in preventing sexual assault by staff.²²²

In 1995, a class action lawsuit challenged severe overcrowding in the Pierce County jail and other deficiencies that were so serious they violated constitutional standards.²²³ Deficiencies included lack of medical and mental health care. The final settlement included specific policies to ensure that medical care for inmates met minimum constitutional standards for humane treatment.²²⁴

Significant improvements have occurred during the past fifteen years.²²⁵ For example, the county has nearly doubled the jail's nursing staff, added mental health staff, and re-established a quality improvement committee whereby outside physicians review deaths and health care issues in order to make recommendations to improve the quality of medical care at the facility.²²⁶

2. Washington's Legislative Response

The Washington Legislature has taken the first steps to address conditions for people with I/DD and TBI in jails and prisons. In 2009, H.B. 2078 passed unanimously, establishing a legislative work group to address issues related to people with I/DD and TBI who are incarcerated in jails and prisons.²²⁷ The work group was co-chaired by the Washington Association

Third Amended Complaint at 2, Doe v. Clarke, No. 7-2-01513-0 (Wash. May 22, 2008) (on file with author).

²²² COLUMBIA LEGAL SERVICES & PILG, *supra* note 217.

²²³ *Pierce County Jail: Improvements in Medical Care to End Suit over Inhumane Conditions*, AM. CIVIL LIBERTIES UNION WASH. ST., (Nov. 29, 2010), <http://www.aclu-wa.org/news/pierce-county-jail-improvements-medical-care-end-suit-over-inhumane-conditions> (discussing *Herrera v. Pierce County*, No. C 95-5025-FDB (W.D. Wash. 1996)).

²²⁴ *Id.*

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ H.B. 2078, 61st Leg., Reg. Sess. (Wash. 2009).

of Sheriffs and Police Chiefs and the Washington State Developmental Disabilities Council.²²⁸

This legislation was, in part, a response to a tragic incident involving the treatment of a man with a developmental disability in the Kitsap County Jail. Bill Trask was arrested for a misdemeanor assault, which most likely occurred as the result of his disability.²²⁹ Although the jail knew he had a developmental disability, no effective action was taken to aid him.²³⁰ After twenty-two days in jail he collapsed and was sent to the hospital.²³¹ He now has severe disabilities, due to brain damage incurred from severe dehydration while incarcerated, and requires total care.²³² As a result of Mr. Trask's treatment, a lawsuit was filed that resulted in \$4.7 million in damages.²³³

The work group recognized that persons with mental illness, and those with I/DD and TBI, who come in contact with the criminal justice system may face significant difficulties. Particular challenges include a limited ability to understand the legal process and institutional rules, difficulty communicating, reluctance to seek assistance, and vulnerability to exploitation.²³⁴

The Work Group also reported that the number of individuals with I/DD or TBI who are in the criminal justice system is not known for several reasons:

There are obstacles to obtaining an accurate estimate: (1) Washington does not currently employ a state-wide screening tool in the corrections system to identify people with I/DD or TBI; (2)

²²⁸ *Id.*

²²⁹ *\$4.7 Million Settlement for Disabled Man*, KING5.COM (June 12, 2009), <http://www.king5.com/news/local/60787027.html> (last updated Sept. 23, 2012).

²³⁰ *Id.*

²³¹ *Id.*

²³² *Id.*

²³³ *Id.*

²³⁴ WORK GROUP REPORT, *supra* note 11, at 2.

there is often a reluctance to self-identify; (3) definitions of I/DD and TBI vary depending on when, how, and why someone is identified; and, (4) not all persons with an I/DD qualify for state or federally funded services and there is no coordinated service system for the excluded population.²³⁵

The work group concluded:

Early identification of I/DD and TBI is essential in ensuring that an individual's rights and safety can be properly maintained, that opportunities for reasonable accommodations are addressed and public safety maximized. Additionally, early identification can assist in avoiding incarceration altogether when appropriate, through diversion and the concomitant attainment of needed community services and supports.²³⁶

As a result of its efforts, the work group developed a model policy, screening tools, and proposed training for identifying inmates with I/DD and TBI in jails and correctional facilities.²³⁷

a) Model Policy

The work group's model policy includes procedures for (1) booking; (2) accommodation during confinement; (3) release planning; and (4) revised training.²³⁸ The model policy was distributed to all sheriffs through the Washington Association of Sheriffs and Police Chiefs. It has been reported

²³⁵ *Id.*

²³⁶ *Id.*

²³⁷ Additional recommendations include (1) improving communication between the jails, DOC, and the Division of Developmental Disabilities (DDD); (2) creating specialized training for community service providers and correctional officers regarding I/DD and TBI; (3) initiating a DOC process to assist the inmate in developing a plan for support upon release; (4) funding Crisis Intervention Training; (5) training and informing judges, public defenders, and prosecutors about I/DD and TBI; (6) utilizing alternatives to incarceration; (7) creating a specialized process for pre-booking diversion; and (8) addressing the role of Community Protection Program as a potential sentencing alternative. *Id.*

²³⁸ *Id.*

that at least two jails, those in Chelan and Kitsap Counties, have incorporated elements of the work group's model policy into their policies.

b) Screening Tool

The work group believed that creating a screening tool would result in important change because "screening can help identify the need for further assessment, assist in offender classification, and determine what reasonable accommodations may be needed by the offender."²³⁹ As a result, a draft tool for screening, called "Intellectual Disability/Traumatic Brain Injury Screening," was developed. Although the draft tool is outlined and printed on DOC stationary, there is no indication the screening tool is being used by the DOC. In speaking with DOC employees responsible for the initial screening, they commented that they had never seen this instrument.²⁴⁰

c) Training

As a follow up to the work group's recognition that early identification of I/DD and TBI is essential to ensure that an individual's rights and safety can be properly maintained, a curriculum was developed and implemented under the direction of the Washington State Criminal Justice Training Commission (WSCJTC).²⁴¹ This curriculum teaches front-line law enforcement about I/DD and TBI²⁴² so that they may create the best possible response system for those with TBI.²⁴³ A pilot class was successfully completed during April 2011 in Spokane, WA.²⁴⁴ WSCJTC is

²³⁹ *Id.* at 4.

²⁴⁰ Interview with Wash. Dep't of Corr. Staff, Wash. Corr. Complex for Women, in Gig Harbor, Wash. (Aug. 2011).

²⁴¹ WASH. STATE DEP'T OF SOC. & HEALTH SERVICES., TRAUMATIC BRAIN INJURY CURRICULUM DEVELOPMENT PROJECT FINAL REPORT 6 (2011), *available at* http://www.tbiwashington.org/documents/FinalReport_WSCJTC.doc.

²⁴² *Id.*

²⁴³ *Id.*

²⁴⁴ *Id.* at 8.

recommending that the training be delivered four times a year. Delivery will depend on funding being provided for the training.²⁴⁵

VI. RECOMMENDATIONS

This article strives to act as a framework for future efforts to address the needs of inmates with I/DD, TBI, and mental illness. This section will discuss issues concerning cost effectiveness, lack of independent oversight, ways to improve communication regarding medical conditions and medications, and reduction of recidivism rates.

A. Cost Effectiveness

As a first step to ease costs, the state of Washington should perform a comprehensive analysis examining the cost of hospitalization and community programs compared to the cost of incarceration to determine if cuts to state hospital and community programs result in a greater financial burden in the criminal justice system.

In addition, when an individual is incarcerated, his/her Medicare and Medicaid benefits are suspended. This puts an additional financial burden on jails and prisons to both provide services without this additional financial resource and hire employees to help inmates reinstate benefits upon release. Medicare and Medicaid should be revised to continue providing benefits to eligible mentally ill people once they are incarcerated, making mental health care easily accessible.

Washington should establish a legislative task force to review oversight of the Washington DOC. This task force would study the feasibility and effectiveness of forming an independent entity to oversee the status of, and conditions within, Washington's prisons and jails. The study would have a particular emphasis on ensuring that people with mental illness, I/DD, or

²⁴⁵ *Id.* at 13.

TBI are treated accordingly. It would also address the use of solitary confinement.

1. Alternatives to Incarceration

Jails and prisons have become de facto mental health providers. To combat this, Washington should expand mental health courts to link defendants who have mental health concerns with treatment programs in the community rather than expand prisons. Like other problem-solving courts—for example, drug courts, domestic violence courts, and community courts—mental health courts seek to address the underlying problems that contribute to criminal behavior in people with mental disabilities. Several counties have mental health courts, which can provide one alternative to the current system.²⁴⁶

Another alternative recommended by the work group is diversion programs;²⁴⁷ however, diversion programs require both legislation and funding. The work group suggested that if appropriate resources and services are available, prisons should implement a specialized pre-booking diversion program to identify offenders with I/DD and TBI.

To varying degrees, it appears each jail makes an effort to divert people when possible. There was also consensus that, as a result of community programs being cut, the jail population has increased, particularly for crimes

²⁴⁶ *Mental Health Courts*, WASH. COURTS, http://www.courts.wa.gov/court_dir/?fa=court_dir.psc&tab=5 (last updated Feb. 19, 2013). These problem-solving courts divert offenders prior to trial or sentencing into treatment settings, with the help of social-service providers to assist with employment, housing, and transportation. *Id.* Mental health courts recognize that offenders bear responsibility, but not full responsibility, for their actions, and that they ought to be offered an alternative to punishment if treatment can help them lead productive, noncriminal lives. *See id.*; BUREAU OF JUSTICE ASSISTANCE, MENTAL HEALTH COURTS PROGRAM (2003), available at <https://www.bja.gov/Publications/MentalHealthCtFS.pdf>.

²⁴⁷ WORK GROUP REPORT, *supra* note 11.

such as trespassing, spitting on a bus, and other similar charges.²⁴⁸ Currently, there are six diversion centers throughout Washington. A seventh diversion center is expected to open in the near future. Some centers are secure; some are not.²⁴⁹ Police are often hesitant to utilize centers that are not secure.²⁵⁰

2. Reduction of Solitary Confinement

Policies that reduce the use of solitary confinement for inmates with mental disabilities, as has been done recently in other states, are essential.²⁵¹ Thus, the DOC should identify the relationship between mental health issues and rule violations, and it should track infractions and the use of solitary confinement for people with mental illness, I/DD, and TBI to determine the total use of and, average length of, solitary confinement for those inmates.

B. Implementing Correctional Oversight

Correctional oversight by an independent entity whose findings are disseminated to the public is a relative rarity in the United States. Oversight provides for transparency of public institutions and accountability for the operation of safe and humane prisons and jails.²⁵² This is important because

²⁴⁸ Interviews with Jail Officials in Snohomish Cnty., Pierce Cnty., Kitsap Cnty., and King Cnty. jails (Nov. 2010–Apr. 2011).

²⁴⁹ A secure facility is a locked-down facility.

²⁵⁰ Interview with Staff at Pierce Cnty. Diversion Center, in Tacoma, Wash. (Dec. 4, 2010).

²⁵¹ In 2011, Colorado enacted Senate Bill 176 to reduce the use of solitary confinement for people with mental disabilities. S.B. 11-176, 68th Gen. Assemb., Reg. Sess. (Co. 2011). Also, in 2011, New Mexico passed Senate Memorial 40 to gather information about the use of solitary confinement. Sen. Memorial 40, 50th Leg., 1st Sess. (2011). Additionally, Maine, under the leadership of new commissioner of Maine Department of Corrections, Joseph Ponte, has had a dramatic reduction in solitary confinement. *Maine's Dramatic Reduction of Solitary Confinement*, THE CRIME REPORT (July 20, 2011, 11:51 PM), <http://www.thecrimereport.org/news/inside-criminal-justice/2011-07-maines-dramatic-reduction-of-solitary-confinement>.

²⁵² Mushlin & Deitch, *supra* note 7, at 1386.

inmates can often become invisible. In 1987, Supreme Court Justice William J. Brennan made the following observations about prisoners and the world in which they live:

Prisoners are persons whom most of us would rather not think about. Banished from everyday sight, they exist in a shadow world that only dimly enters our awareness. They are members of a 'total institution' that controls their daily existence in a way that a few of us can imagine.²⁵³

This is still true today. Often the only oversight for prisons and jails is through litigation, after the harm has occurred.

There are a number of good reasons for independent oversight. For one, public identification of significant problems can lead to the rectification of those problems, resulting in safer facilities.²⁵⁴ Some monitoring of correctional institutions does occur in the United States, such as through the DOJ Civil Division.²⁵⁵ In addition, the Prison Rape Elimination Act requires the Bureau of Justice Statistics to carry out a yearly, "comprehensive statistical review and analysis of the incidence and effects of prison rape."²⁵⁶

Prison oversight is valued in other countries. For example, prisons in all of the countries (over forty-five) that are members of the European Union are subject to independent monitoring by the European Committee for the Prevention of Torture (CPT).²⁵⁷ The United Kingdom also utilizes an

²⁵³ O'Lone v. Estate of Shabazz, 482 U.S. 342, 354 (1987) (Brennan, J., dissenting).

²⁵⁴ See Mushlin & Deitch, *supra* note 7, at 1398–1401.

²⁵⁵ This was authorized by the Civil Rights of Institutionalized Persons Act. Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (1980), as well as the Inspector General of the DOJ, the California Inspector General, the Ohio Correctional Institutions Inspection Committee, the Texas Youth Commission's Office of the Independent Ombudsman, the Correctional Association of New York, and the New York City Board of Corrections. Mushlin & Deitch, *supra* note 7, at 1385.

²⁵⁶ 42 U.S.C. § 15603 (2003).

²⁵⁷ Mushlin & Deitch, *supra* note 7, at 1392.

independent monitoring entity.²⁵⁸

There is strong support for expanding external oversight of prisons and jails in the United States.²⁵⁹ At a conference on prison oversight in 2006, 115 of the world's top experts on correctional oversight convened at the University of Texas at Austin to discuss a variety of domestic and international oversight models.²⁶⁰ The diverse group of stakeholders represented at the conference—correctional administrators, judges, human rights advocates, policymakers, representatives of prison monitoring bodies, and scholars—reached a consensus about the value of and the need for expanded external oversight of prisons and jails in the United States.²⁶¹

Following the conference, in 2008, the ABA passed a resolution urging federal, state, and territorial governments to “establish public entities that are independent of any correctional agency to regularly monitor and report publicly on the conditions in all prisons, jails, and other adult and juvenile correctional and detention facilities operating within their jurisdiction.”²⁶² The Prison Rape Elimination Commission endorsed the ABA's resolution.²⁶³ Additionally, in 2010, the ABA adopted a revised set of criminal justice standards on the treatment of prisoners that similarly emphasized the importance of independent oversight mechanisms.²⁶⁴

Prison oversight should “seek to promote both public transparency of correctional institutions and accountability for the protection of human

²⁵⁸ *Id.*

²⁵⁹ *Id.* at 1393.

²⁶⁰ *Id.* at 1383–84.

²⁶¹ *Id.* at 1384–85.

²⁶² Stephen J. Saltzburg, *Report to the House of Delegates*, 2008 A.B.A. SEC. CRIM. JUST., available at http://www.americanbar.org/content/dam/aba/publishing/criminal_justice_section_newsletter/crimjust_policy_am08104b.authcheckdam.pdf.

²⁶³ NAT'L PRISON RAPE ELIMINATION COMM'N REPORT, *supra* note 16, at 9.

²⁶⁴ A.B.A. SEC. CRIM. JUST., ABA CRIMINAL JUSTICES STANDARDS ON THE TREATMENT OF PRISONERS (2010), available at http://www.americanbar.org/content/dam/aba/publishing/criminal_justice_section_newsletter/treatment_of_prisoners_commentary_website.authcheckdam.pdf.

rights.”²⁶⁵ Given the closed and invisible nature of prisons, independent oversight is necessary.

C. Steps to Improve Communication Between Jails and the DOC

In 2011, the Washington Legislature recognized the need to remedy the lack of communication between jails and the DOC. HB 1718 directs jail staff to make every reasonable effort to communicate with the DOC regarding the nature of any disability or additional accommodations that may be required by an inmate upon his or her transfer. For instance, under this bill, jail staff must inform the DOC if an inmate needs a lower bunk due to a back injury, or if an inmate requires the use of diabetic shoes.²⁶⁶ This is especially important in regards to medicine and medical conditions because untreated conditions can cause an inmate to deteriorate. Jails and the DOC must work together to improve communication regarding physical needs, mental health care, and medications.

The DOC should also implement a medication review system. The review should include an analysis of inmates who have refused medications to determine if the refusals are the result of a change of medication or of inappropriate medications being administered. Additionally, the DOC should develop a policy to review medications on a regular basis to ensure that proper medications are being prescribed. This is particularly important for psychotropic medications that are prescribed without a mental health diagnosis.

The DOC must screen for TBI in jails and prisons upon entry. Recently, a screening tool to identify TBI was developed specifically for use by jails and prisons. This tool is available for free, and it should be utilized by all

²⁶⁵ See Mushlin & Deitch, *supra* note 7, at 1410.

²⁶⁶ H.R. 1718, 62nd Leg., Reg. Sess. (Wash. 2011).

facilities that house incarcerated populations.²⁶⁷

The DOC and jails should actively invite family members and community mental health providers to share medical and mental health information with correctional facilities. All jails and the DOC should clearly post on their websites phone numbers and email addresses that family members or community health or mental health professionals can call to pass along important health-related information.

E. Improving Reentry into Society and Benefits for Washington Inmates

Reinstating inmates' benefits at release can save lives. A study of recently released Washington inmates found that during the first two weeks following release, the risk of death among former inmates was 12.7 times that of other state residents, with a marked elevated risk of death from drug overdose. The leading causes of death among former inmates were drug overdose, cardiovascular disease, homicide, and suicide.²⁶⁸ It is well established that people will often self-medicate as a result of not being on proper medication or receiving appropriate mental health treatment.²⁶⁹

In 2006, the Washington Legislature took the initial steps toward improving release procedures with HB 1290.²⁷⁰ Section twelve of the bill requires the Department of Social and Health Services (DSHS) to adopt rules and policies allowing persons with mental disorders who were enrolled in medical assistance immediately prior to confinement to have their medical assistance coverage fully reinstated on the day they are

²⁶⁷ Interview with John Corrigan, M.D., Director, Ohio Valley Ctr. for Brain Injury Prevention and Rehab. (Sept. 2, 2011).

²⁶⁸ Ingrid A. Binswanger et al., *Release from Prison—A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157 (2007), available at <http://www.nejm.org/doi/full/10.1056/NEJMsa064115>.

²⁶⁹ Elizabeth Hartney, *The Self Medication Theory of Addiction: People Self Medicate Underlying Problems with Drugs and Addictive Behavior*, ABOUT.COM (July 15, 2011), http://addictions.about.com/od/aboutaddiction/a/self_medication.htm.

²⁷⁰ H.R. 1290, 59th Leg., 2005 Reg. Sess. (Wash. 2005).

released from confinement.²⁷¹ In 2011, the I/DD and TBI offender workgroup report recommended expansion of this policy to encompass inmates with I/DD or TBI. In its original version, HB 1718 addressed this issue, but unfortunately it was eliminated due to the fiscal impact of the work associated with arranging for benefits for these individuals upon release.²⁷²

Additionally, DSHS, the Washington Association of Sheriffs and Police Chiefs, the DOC, and Regional Support Networks are expected to establish procedures that coordinate programs ensuring prompt reinstatement of eligibility and speedy eligibility determinations for persons who are likely to be eligible for medical assistance services upon release from confinement.²⁷³

The DOC currently tracks the number of applications for medical benefits of released inmates and the number of applications that are actually completed with its “Annual Behavioral Health Score.”²⁷⁴ While this reporting shows that 93 percent of applications were completed, it does not appear to track how many of the applications were approved or whether inmates actually left incarceration with their benefits reinstated.²⁷⁵

In January 2011, the author and Linda Worthington, former director of the Disabled Homeless Advocacy Project of the Seattle Community Law Center,²⁷⁶ met with the DOC employees charged with implementing HB

²⁷¹ *Id.*

²⁷² Compare H.B. 1718, 62nd Leg., Reg. Sess. (Wash. 2011), with Act effective July 22, 2011, ch. 236, 2011 Wash. Laws.

²⁷³ H.R. 1290, 59th Leg., Reg. Sess. (Wash. 2005).

²⁷⁴ WASH. DEP’T OF CORR., ANNUAL BEHAVIOR HEALTH SCORE (on file with author).

²⁷⁵ *Id.*

²⁷⁶ The Seattle Community Law Center provides high-quality Social Security and SSI representation to people who need benefits the most and who are least likely to secure representation due to barriers preventing them from accessing the justice system. See generally *About SCLC*, SEATTLE CMTY. LAW CTR., http://seattlecommmlaw.org/index.php?option=com_content&view=category&layout=blog&id=34&Itemid=55 (last visited Nov. 4, 2012).

1290 at the Monroe Correctional Complex. The employees were dedicated to ensuring that inmates left with their benefits.²⁷⁷ Their main complaint, however, was the unreasonable number of DSHS (GA-U/GA-X at the time, now DL-U/DL-X) denials that they received.²⁷⁸ They were provided no support in how to efficiently submit their clients' paperwork in order to streamline the approval process.²⁷⁹ At the time of the meeting, DOC staff indicated that they were not submitting SSI applications as a priority because their main concern was getting each person onto DSHS benefits as of the day of release.²⁸⁰ DOC staff also indicated that this was not happening due to DSHS's failure to partner with them.²⁸¹ When working with different systems in order to provide continuity of services, it is critical the different agencies work together.

VII. CONCLUSION

The United States incarcerates more people than any other country in the world, with 2.3 million people in the nation's prisons or jails today. This is a five-fold increase over the past thirty years. With this dramatically increased population, jails and prisons have become de facto mental health hospitals. Jails and prisons are designed around security, safety, and control, and while they are not designed to be comfortable, inmates still have a constitutional right to physical and mental health treatment while incarcerated.

Inadequate support from elected officials and punitive anti-crime measures have led to a growing number of incarcerated persons with mental

²⁷⁷ Interviews with Wash. Dep't of Corr. Officials, Monroe Corr. Complex, in Monroe, Wash. (Oct.14, 2010, Nov.18, 2010, Dec.22, 2010, Jan.13, 2011, May 16, 2011, June 24, 2011, July 28, 2011). This information is also based on the author's review of records and personal observations.

²⁷⁸ *See id.*

²⁷⁹ *See id.*

²⁸⁰ *See id.*

²⁸¹ *See id.*

illness. Prisons were never intended as facilities for the mentally ill, yet that is one of their primary roles today. Many of the men and women who cannot get mental health treatment in the community are swept into the criminal justice system after they commit a crime. Offenders who need psychiatric interventions for their mental illnesses should be held in secure facilities if they have committed serious crimes, but those facilities should be designed and operated to meet the treatment needs of the mentally ill. Many correctional officials recognize the challenges posed to their work because of the increase of inmates with mental illness.

The Washington legislature recognized the unique problems for those with I/DD or TBI and the need to provide treatment and appropriate accommodation. Society does not benefit from incarcerating offenders with mental illness, I/DD, and TBI in an environment that is counter-therapeutic and, at times, dangerous to the mental and physical well-being of inmates.

In Washington, there are competent and committed mental health professionals who struggle to provide good mental health services to those who need them. They face significant challenges—including working within facilities and rules designed primarily to punish. It is difficult, if not impossible, to provide adequate treatment in a punishment paradigm.

Unfortunately, prisoners and inmates are not a powerful public constituency. Historically, legislative and executive branch officials have ignored prisoners' rights in the absence of pending litigation or the threat of such litigation. Lawsuits alleging violations of the US Constitution can only accomplish so much. Courts have held that officials violated the US Constitution only when they were "deliberately indifferent"²⁸² to prisoners' known and serious mental health needs. Neglect or malpractice does not constitute a violation of a prisoner's constitutional rights.²⁸³

Laws are created to protect the fundamental values of society, including

²⁸² *Estelle v. Gamble*, 429 U.S. 97 (1976).

²⁸³ *Id.*

the respect for the inherent dignity of all human beings. As a society we cannot ignore the conditions inside jails and prisons, and something must be done to address not only the rights of inmates on the whole, but especially the rights of individuals with I/DD, TBI, and mental illness.